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OFFICE OF THE STATE COMPTROLLER

September 6, 2024

DaMia Harris-Madden, Ed.D.
Commissioner
Office of Children and Family Services
52 Washington Street
Rensselaer, NY 12144

Re: Oversight of Child Protective Services
Report 2024-F-6

Dear Dr. Harris-Madden:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Office of Children and Family Services (OCFS) to implement the recommendations contained in our initial audit report, *Oversight of Child Protective Services* (Report 2021-S-17).

Background, Scope, and Objective

The New York State Child Protective Services (CPS) Act of 1973 was established to encourage more complete reporting of child abuse and maltreatment, provide for the swift and competent investigation of such reports, protect children from further abuse or maltreatment, and provide rehabilitative services. OCFS is responsible for overseeing the locally administered child welfare system, including 58 local departments of social services (LDSSs) and the voluntary agencies that contract with LDSSs to provide child welfare services.

OCFS receives suspected incidences of child abuse and maltreatment through the Statewide Central Register of Child Abuse and Maltreatment (SCR) via phone calls, mail, fax, and electronic submissions (hereafter, suspected incidences of child abuse and maltreatment received by the SCR are referred to as "calls"). The SCR, established by New York Social Services Law, is available 24 hours a day, 7 days a week, 365 days a year, and received approximately 313,000 calls in 2023. If a call is received and OCFS staff determine there is reasonable cause to suspect that a child (i.e., under the age of 18) has been impaired or is in imminent danger of impairment because of the failure of a parent or person legally responsible to exercise a minimum degree of care, OCFS will create an intake report if it is within the jurisdiction of the State and sufficient demographics (e.g., name, address) are provided to initiate an investigation. Calls with concerns that do not contain those elements result in a non-report. In such instances, the caller must be provided with a clear explanation of why the call is not being registered as a report and given the option to receive a supervisory consultation. Examples of circumstances that would result in a non-report include those related to children age 18 or older and children residing outside of New York State.

Calls received through the SCR that OCFS staff determine meet the threshold for a report are sent to the respective LDSS through CONNECTIONS—the computerized system of

record used for recording child welfare information in the State. Staff also use CONNECTIONS to document all case activity during their investigations of CPS cases. Select information for calls that do not meet the threshold for a report, including closure codes denoting the reason calls were closed, are also entered into CONNECTIONS.

In certain instances, reports of abuse or maltreatment involve the death of a child. OCFS is required by law to conduct a review and issue a summary report within 6 months of the death of the child. To improve practices within LDSSs, OCFS implemented a Program Quality Improvement (PQI) process in January 2020. The process involves case reviews by a dedicated team to improve consistency. Once a review of the LDSS is completed, OCFS issues a report to the LDSS identifying any findings. If needed, a program improvement plan (PIP) is put in place and monitored by OCFS.

The objective of our initial audit, issued in January 2023, was to determine whether OCFS was effectively overseeing LDSSs' investigation of reports of alleged child abuse or maltreatment, and ensuring compliance with relevant laws, regulations, and procedures to promote the safety and well-being of affected children and families. The audit covered the period from January 2018 through November 2021, with subsequent information related to our sampled cases through September 2022. The audit found that OCFS could make improvements to child fatality and PQI reviews. The prevalence of certain issues across multiple LDSSs indicated problems that should be addressed statewide rather than on a case-by-case basis; however, officials had not yet developed a plan on how to do so. Further, we found closure codes for non-report calls could more accurately reflect the nature of closure and why the call did not result in a report. Additionally, the length of time OCFS maintained call recordings from the SCR may have limited its ability to retroactively investigate whether non-report calls were properly handled. Several investigations in our sample lacked evidence to support the completion of all required steps.

The objective of our follow-up was to assess the extent of implementation, as of May 2024, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

OCFS officials have made some progress in addressing the issues we identified in the initial audit; however, additional actions are needed. Of the initial report's three recommendations, one has been implemented and two have been partially implemented.

Follow-Up Observations

Recommendation 1

Establish procedures to more accurately reflect the nature of the calls determined to be non-reports and the reason why the call did not result in a report; this may include, but not be limited to, adjusting the retention period for the call recording and updating closure codes.

Status – Implemented

Agency Action – In September 2023, OCFS created five additional closure codes in CONNECTIONS to reflect more accurately the reason when a call does not result in a report. These new codes cover various scenarios, such as whether the call was disconnected before the caller was able to provide adequate information or whether complete information could not be obtained because of IT issues (e.g., the caller, such

as a school, can't provide information because their computer system is down). During our follow-up, we were able to review the five closure codes and confirm OCFS staff were able to use them to reflect the reasons calls do not result in a report. OCFS officials stated they also assessed the current retention period for maintaining call recordings and believe the current retention period is adequate and will not be adjusting it.

Recommendation 2

Evaluate and address deficiencies found in PQIs and child fatality reviews on a statewide basis across all LDSSs.

Status – Partially Implemented

Agency Action – Since our initial audit, OCFS has begun evaluating deficiencies that were identified in local PQI reviews to identify statewide factors that are impacting local performance. In addition, the PQI team has met twice since our initial audit to review issues that have already been identified as prevalent across multiple LDSSs and has developed recommendations for statewide policy and procedure changes. These changes include the use of a new case review form and the creation of a standardized process to develop, approve, monitor, and close out PIP items. Once fully implemented, the standardized process should help OCFS address common issues statewide rather than on a case-by-case basis. OCFS began a pilot phase for some of the changes in February 2024 and expects all changes will be fully implemented statewide by the end of 2024.

Recommendation 3

Work with LDSS staff to improve investigation file documentation, including ensuring case notes are sufficiently detailed and entered timely.

Status – Partially Implemented

Agency Action – The recently implemented statewide policy and procedure changes mentioned in Recommendation 2 include the use of a new CPS case form and a revised Family Assessment review form. These forms will help OCFS during its quality assurance process to identify file documentation concerns noted in our original audit report, such as documenting the assessment of a child's environment. However, OCFS officials did not provide any evidence that they have enhanced their monitoring to ensure case notes are sufficiently detailed and entered timely. OCFS officials stated they are unable to ensure that LDSS case notes are sufficiently detailed and entered timely because OCFS can only look at what happened after the fact. Officials also said that just because a case note wasn't entered into CONNECTIONS in a timely manner doesn't mean it wasn't drafted at the time of the activity. According to OCFS, LDSSs often use their own systems to record notes and then transfer information into CONNECTIONS. While we recognize that LDSS staff are responsible for entering progress notes while also directly supervising caseworkers, OCFS could improve its monitoring to help ensure the safety of children involved and the accountability of the LDSSs over the investigation conducted.

Officials also said they continue to offer case documentation training courses that cover documentation standards, how to write effective progress notes, and timeliness.

However, these training courses existed prior to our initial audit, and the training is still mandatory only for newly hired employees.

Major contributors to this report were Holly Thornton, Kathleen Garceau, and Karen Corbin.

OCFS officials are requested, but not required, to provide information about any actions planned to address the unresolved issues discussed in this follow-up within 30 days of the report's issuance.

Very truly yours,

Andrea LaBarge
Audit Manager

cc: Bonnie Hahn, Office of Children and Family Services